operations from GPs book patients in to clinics before placing them on a waiting list.

As part of an initiative programme to reduce waiting times at King's College Hospital in London, GPs were given an opportunity to book patients with eyelid pathology directly onto the minor operations list over a 6-week period. We audited this data retrospectively.

There were 85 subjects (50 males and 35 females) with a mean age of 41.6 years (range 16–75 years). The referring diagnoses were divided into three categories: chalazion/cyst (80% of referrals); skin tag/papilloma (16%); and unknown aetiology (4%). When compared with the diagnoses made by the senior attending ophthalmologists, there was a 34% diagnostic discrepancy. The main discrepancy (65% of cases) occurred in the skin tag/papilloma group (referred initially as cysts). The unknown group contained skin tags/papillomas (66%), and cysts (34%).

Analysis of the final outcome revealed that 26% of patients did not require (or want) surgery; these patients were discharged. The proportion of those discharged was directly related to the length of time between referral and the appointment, which averaged about 3 months.

The clinical diagnosis of benign eyelid lesions at ophthalmic departments has been shown to be fairly accurate when compared to histological samples,[1] in particular for chalazia (up to 94%). However, where discrepancy occurs the lesions often have a premalignant or malignant aetiology.[2,3]

The accurate diagnosis of ophthalmic conditions is clearly in the best interests of all parties involved, and would optimise the use of resources in the treatment of conditions considered suitable for management as 'minor ops'. Improvement in this arena has been demonstrated by organising workshops in some units. Furthermore, it appears that including ophthalmology as part of vocational training is the best way of achieving this aim.[4]

The direct-access pilot scheme was not shown to be an efficient way of conducting the minor operations service. A picture of the lesion may help the ophthalmologist decide where and when to list the patient. In addition, targeted training/workshops for GPs, and a telephone interview with the patient a week prior to their visit in order to confirm the continued presence of a troublesome lesion, may reduce the day-of-surgery discharge rate.

SHAHRAM KASHANI
Senior House Officer in Ophthalmology
Normanby Block Level 2, Kings College Hospital, Denmark Hill, London SE5 9RS.
E-mail: shahdoc@hotmail.com

MOHAMMAD MUHTASEB
Senior Registrar in Ophthalmology

FIONA ROBINSON
Consultant Ophthalmic Surgeon

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The problems with choice

Mike Fitzpatrick[1] is correct. The perverse truth is that inequity is a necessary precondition for choice to be meaningful.

The choice evangelists try to repel their critics by quietly conflating consumer choice with moral choice and rights talk. It is important, therefore, to distinguish between consumerism (the preoccupation with, and increase in, consumption), and moral choice (the patient's inalienable authority to give and withhold consent).

If patient choice drives quality and empowerment, to where is it driving it? A state of equity, and satisfaction for all, by way of the necessary evil of market forces. Who said Marxism was dead?

JOHN MAGUIRE
General Practitioner
Wibsey Medical Centre, Wibsey, Bradford BD6 1TD. E-mail: johnp.maguire@virgin.net

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The stethoscope and cross-infection revisited

Jevons first reported methicillin resistant *Staphylococcus aureus* (MRSA) in 1961[1] and it has now become a serious cause for concern in UK hospitals. Indeed, it has even entered the political arena.[2] In 2003, a search for MRSA using www.yahoo.com yielded 153 000 results; this has now risen to 329 000 references.

Last year, a letter of mine was published here; it detailed a bacteriological examination of my practice stethoscope, which showed that it did not carry MRSA bacteria over a 2-week period.[3] I have since examined 50 stethoscopes chosen at random. They were in daily use by doctors in general practice in the London area drawn from the membership of the Independent Doctors Forum. Their stethoscope bells and diaphragms were imprinted on blood agar medium plates, which were then incubated for 24 hours at 37°C. The Doctors Laboratory examined those culture plates that grew bacteria and identified these bacteria, further testing staphylococci to establish if they were MRSA species.

Of the 50 stethoscopes examined, 13 carried no bacteria at all, 15 carried mixed skin flora, and coagulase negative staphylococci were isolated in 22. Not one of these 50 stethoscopes carried MRSA. This can be contrasted with previous studies, and particularly with a paper by Smith *et al*,[4] which showed that in 1996 in the hospital environment, MRSA frequently colonised stethoscopes used on medical and surgical wards. They found 68 out of 200 stethoscopes (34%) to be positive for MRSA; comparing this with my results, a ^{2} test gives $P<0.001$, which is highly significant.

My study, therefore, clearly demonstrates that the stethoscope is not a vector for MRSA in the community. This observation strongly suggests, but does not prove, that MRSA presents a problem in the UK that is confined to the hospital environment.

STUART SANDERS
General Practitioner
22 Harmont House, 20 Harley Street, London W1G 9PH.
E-mail: drsanders@msn.com

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C-reactive protein values in viral respiratory infections

We welcome the paper by Melbye *et al* on the course of C-reactive protein (CRP) response in upper respiratory tract infection.[1] It provides valuable insight, broken down by virus type. However, the design of the study may possibly limit the generalizability of its results.

From the title and the abstract we are tempted to believe that all episodes that were treated with an antibiotic, were excluded. However, it is not clear to us what the indication for antibiotic prescription was. In the methods section, we read that, 'subjects were excluded if a bacterial infection was suspected and antibiotics were prescribed'. The ambiguous word in this sentence seems to be 'and'. When patients were prescribed antibiotics, did the investigators verify that it was a bacterial infection or did they assume that the GP had thought this?

Without doubt, the authors are aware of the fact that GPs frequently prescribe antibiotics for diseases of viral origin. The seriousness of the disease might well have played a role in the decision to prescribe antibiotics, indicating that those patients who were seriously ill were not included. Perceived patient preference is another reason. Further studies are needed that take a more comprehensive view on CRP in respiratory tract infections presented to general practice.

JOHANNES C VAN DER WOUDEN
Senior Lecturer
Department of General Practice, Erasmus Medical Centre, University Medical Center Rotterdam, Rotterdam, The Netherlands.
E-mail: j.vanderwouden@erasmusmc.nl

MIRIAM MONTENY

MARJOLEIN Y BERGER
General Practitioner

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Author's response

We wanted to demonstrate the natural course of the C-reactive protein (CRP) response during viral respiratory infections, and none of the patients described in our study were treated with antibiotics.

Our material is, as van der Wouden *et al* comment on, not sufficiently representative of the upper respiratory tract infections we meet in general practice. The most severe viral infections may have been excluded, and we know from previous studies that CRP values above 100 mg/l may be found in influenza and adenovirus infections.[1] I agree with van der Wouden *et al* that more systematic research is needed in this field. However, some useful information may be obtained from our study.

The CRP response in viral respiratory infections has some typical features. The maximum CRP value is reached when the illness has lasted 2–4 days, and falls rapidly over the following days. Values below 10 mg/l is the rule after 7–10 days in uncomplicated cases. These features have also been indicated by other studies.[2,3] This knowledge can be taken into consideration when results of the CRP test are interpreted in patients with acute cough or a flu-like illness.

HASSE MELBYE
Professor of General Practice
University of Tromsø, Tromsø, Norway.
E-mail: hasse.melbye@ism.uit.no

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Time to acknowledge the workings of the 80/20 principle?

Julian Tudor-Hart has devoted his life to demonstrating and exposing the inverse care law[1–3] and the rule of halves.[4] There is a part of me that shares his anger that such inequitable distributions exist and persist.

However, I wonder whether what Tudor-Hart has described in the medical context is actually another example of the Pareto principle of asymmetric rewards, popularly known as the 80/20 principle. We see multiple examples of this principle in action. For example:

- A university department that is doing well gets a better research assessment evaluation, and so more money with which to do better still.
- An author who has been published once is much more likely to be published again, even if new and better authors are emerging.
- Twenty per cent of patients will take up 80% of available appointments.
- A surgery with many settled and loyal